PLAN OF CARE

A plan of care must be developed for all ACP cases. The plan of care is developed throughout the assessment in MiAIMS.

- The plan of care directs the movement and progress toward goals identified jointly by the client, the facility and by the adult services worker.
- The plan of care is person-centered and strength-based.
- Participants in the plan should involve not only the client, but also family, significant others, and the caregiver.

The plan of care is to be completed on all new cases and updated as often as necessary. Minimally, the updates occur at the six month review. Areas of concern need to be identified in the comprehensive assessment to properly develop a plan of care.

A copy of the ACP Plan of Care and signature page (**MDHHS-5536 and MDHHS-5537**) must be given or mailed to the AFC provider within **five business days** of the home visit.

PLAN OF CARE DEVELOPMENT PRACTICES

The plan of care development practices will include the use of the following skills:

- Actively **listen** to the client.
- Actively **communicate** with the licensed homeowner/or home manager.
- Encourage clients to **explore options** and select the appropriate services and supports.
- Monitor for congruency between case assessment and the plan of care.
- Provide the necessary **supports** to assist clients in applying for resources.
- Continually **reassess** case planning.
- Enhance/preserve the client's **quality of life**.

- **Monitor** the status of all **referrals** to community resources to **ensure quality outcomes**.
- Behavioral plans **must be addressed** in the plan of care **prior to implementation** per licensing regulations.